



Missouri Pharmacy Program – Preferred Drug List



Inhaled Antibiotic Agents

Effective 05/21/2008

Revised 07/09/2015

Preferred Agents

*Step Therapy Criteria Apply

- Bethkis®
- Tobi®
- *Tobi Podhaler®

Non-Preferred Agents

- Cayston®
- Tobramycin
- **Kitabis Pack**

<u>Approval Criteria</u>	<u>Denial Criteria</u>
<ul style="list-style-type: none">• Failure to achieve desired therapeutic outcomes with trial on 1 or more preferred agents<ul style="list-style-type: none">○ Documented trial period for preferred agents○ Documented ADE/ADR to preferred agents	Lack of adequate trial on required preferred agents
<ul style="list-style-type: none">• Documented compliance on current therapy regimen	Therapy will be denied if no approval criteria are met
<ul style="list-style-type: none">• Tobi Podhaler (only)<ul style="list-style-type: none">○ Available after trial on tobramycin inhaled product	Drug Prior Authorization Hotline: (800) 392-8030